

CERTIFICATE OF DEATH

Reg. Dist. No.

05423

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Curtis E. Bledsoe</u>		4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/1891</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>chicken</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Bledsoe</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Dalton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MARY Bledsoe, Hillsboro, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 16, 1958</u> to <u>May 29, 1959</u> , that I last saw the deceased alive on <u>May 23, 1959</u> , and that death occurred at <u>8:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kurt Lederer</u>		ADDRESS (Street, city or town, state) <u>Queen Anne, Md.</u> DATE SIGNED <u>5/27</u>	
PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>5/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Denton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanna</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u>	
ADDRESS <u>Arthur S. Hanna, Denton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
DATE <u>JUN 8 '59</u>			

CERTIFICATE OF DEATH

00 003

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1. Name of Deceased: JOHN J. BROWN

2. Sex: Male

3. Date of Birth: 10-15-1890

4. Place of Birth: NEW YORK

5. Date of Death: 10-25-1960

6. Place of Death: NEW YORK

7. Cause of Death: Heart Disease

8. Duration of Illness: 10 days

9. Name of Physician: Dr. J. J. Smith

10. Name of Undertaker: John J. Brown

11. Name of Burial Place: St. John's Cemetery

12. Name of Minister: Rev. J. J. Smith

13. Name of Registrar: John J. Brown

14. Name of Coroner: John J. Brown

15. Name of Jury: John J. Brown

16. Name of Jury: John J. Brown

17. Name of Jury: John J. Brown

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100. Name of Jury: John J. Brown

CERTIFICATE OF DEATH

Reg. Dist. No.

5433

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural		c. LENGTH OF STAY IN 1b 45 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		/d. STREET ADDRESS none	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ada Briggs Brady		4. DATE OF DEATH Month Day Year May 7 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Mary Camper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Olin Briggs,		Address Federalsburg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hrs 8 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1954 to May 7 1959 , that I last saw the deceased alive on May 7 1959 , and that death occurred at S.A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Federalsburg, Md DATE SIGNED 5/9/59 ACTUAL SIGNATURE Frank M. Anderson M.D. PHYSICIAN'S NAME (Type) Frank M. Anderson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 9, 1959	22c. NAME OF CEMETERY OR CREMATORY Skinner's Run	22d. LOCATION (City, town, or county) (State) Federalsburg, Md. R. F. D.
23. FUNERAL DIRECTOR'S SIGNATURE Harvey W. Wilson		24a. REC'D BY REGISTRAR DATE MAY 12 59	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

1. Name of deceased

2. Sex

3. Date of birth

4. Place of birth

5. Date of death

6. Place of death

7. Cause of death

8. Duration of illness

9. Name of physician

10. Name of funeral director

11. Name of undertaker

12. Name of cemetery

13. Name of church

14. Name of family

15. Name of next of kin

16. Name of executor

17. Name of administrator

18. Name of guardian

19. Name of trustee

20. Name of agent

21. Name of attorney

22. Name of clerk

23. Name of treasurer

24. Name of secretary

25. Name of member

26. Name of officer

27. Name of director

28. Name of president

29. Name of vice president

30. Name of secretary

31. Name of treasurer

32. Name of member

1

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 10

5434 CERTIFICATE OF DEATH

Reg. Dist. No. 05425

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. LENGTH OF STAY IN 1b 3 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arville Middle Brown Last Brown		4. DATE OF DEATH Month 5 Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1905
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 5 Days 4 Hours 19 Min. 59	IF UNDER 24 HRS. Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William T. Brown	
14. MOTHER'S MAIDEN NAME Ammie Mason		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 221-18-3037		17. INFORMANT James L. Brown Address 149 N. Queen St. Dover Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr. 15, 19 59 , to May 4, 19 59 , that I last saw the deceased alive on May 4, 19 59 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 5/7/59			
ACTUAL SIGNATURE Charles H. Stonesifer M.D.		PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/7/59	22c. NAME OF CEMETERY OR CREMATORY Union	22d. LOCATION (City, town, or county) (State) Goldsboro, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulain ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR DATE MAY 11 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5435 **CERTIFICATE OF DEATH**

05426

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>CAROLINE</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>CAROLINE</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DENTON</u>	LENGTH OF STAY (in this place) <u>40 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DENTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>FRANK</u> (Middle) <u>DENNIS</u> (Last)		(Month) <u>MAY</u> (Day) <u>27</u> (Year) <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 12, 1883</u>
9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POLICE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Washington DENNIS</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Emory</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>8</u>	
17. INFORMANT & ADDRESS <u>Mrs Harlow Edwards Denton</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage with hemiplegia</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 10, 1958</u>, to <u>May 27, 1959</u>, that I last saw the deceased alive on <u>Ma y 26, 1959</u>, and that death occurred at <u>7 A.</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Charles H Stover</u> M.D.		DATE SIGNED <u>May 29 '59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. DATE THEREOF <u>May 30, 1959</u>	
25. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		26. LOCATION (City, town, or county) (State) <u>Denton Md</u>	
24. REC'D BY REGISTRAR <u>Charles E. Kenna</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Kenna</u>	
DATE <u>JUN 3 '59</u>		ADDRESS <u>Denton</u>	

188

STATE OF ALABAMA DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Form No. 1

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Cause of death: _____

7. Date of death: _____

8. Place of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Signature of informant: _____

12. Signature of witness: _____

13. Signature of funeral director: _____

14. Signature of undertaker: _____

15. Signature of cemetery: _____

16. Signature of burial place: _____

17. Signature of interment: _____

18. Signature of final disposition: _____

19. Signature of final resting place: _____

20. Signature of final burial place: _____

21. Signature of final interment: _____

22. Signature of final disposition: _____

23. Signature of final resting place: _____

24. Signature of final burial place: _____

25. Signature of final interment: _____

26. Signature of final disposition: _____

27. Signature of final resting place: _____

28. Signature of final burial place: _____

29. Signature of final interment: _____

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, ALABAMA, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE FUNERAL HOME OR TO THE PERSON IN CHARGE OF THE BURIAL.

5436

CERTIFICATE OF DEATH

05427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 05 Penna. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro		c. LENGTH OF STAY IN 1b 1 Yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Croydon	
3. NAME OF DECEASED (Type or print) First Middle Last Herman Horn		4. DATE OF DEATH Month Day Year 5 22 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/1893
9. AGE (in years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician	11. BIRTHPLACE (State or foreign country) Phila., Pa.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician		10b. KIND OF BUSINESS OR INDUSTRY None	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel Horn		14. MOTHER'S MAIDEN NAME Rebecca Mueller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 179-12-6278	
17. INFORMANT Alice Horn Greensboro, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Spontaneous Cardiac Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Spontaneous</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 14, 1959</u> , to <u>May 22, 1959</u> , that I last saw the deceased alive on <u>May 14, 1959</u> , and that death occurred at <u>9 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Wright</u>		DATE SIGNED <u>MAY 23, 1959</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT H. WRIGHT MD GREENSBORO MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/59	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	22d. LOCATION (City, town, or county) (State) Somerton, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulos in Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE MAY 25 '59	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK CERTIFICATE OF DEATH

Decedent's Name _____		Date of Death _____	
Place of Birth _____		Age at Death _____	
Sex _____		Race _____	
Usual Residence _____		Cause of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Burial _____		Place of Burial _____	
Signature of Next of Kin _____		Signature of Coroner _____	
Date of Issuance _____		Office of the Registrar _____	

1

543 CERTIFICATE OF DEATH

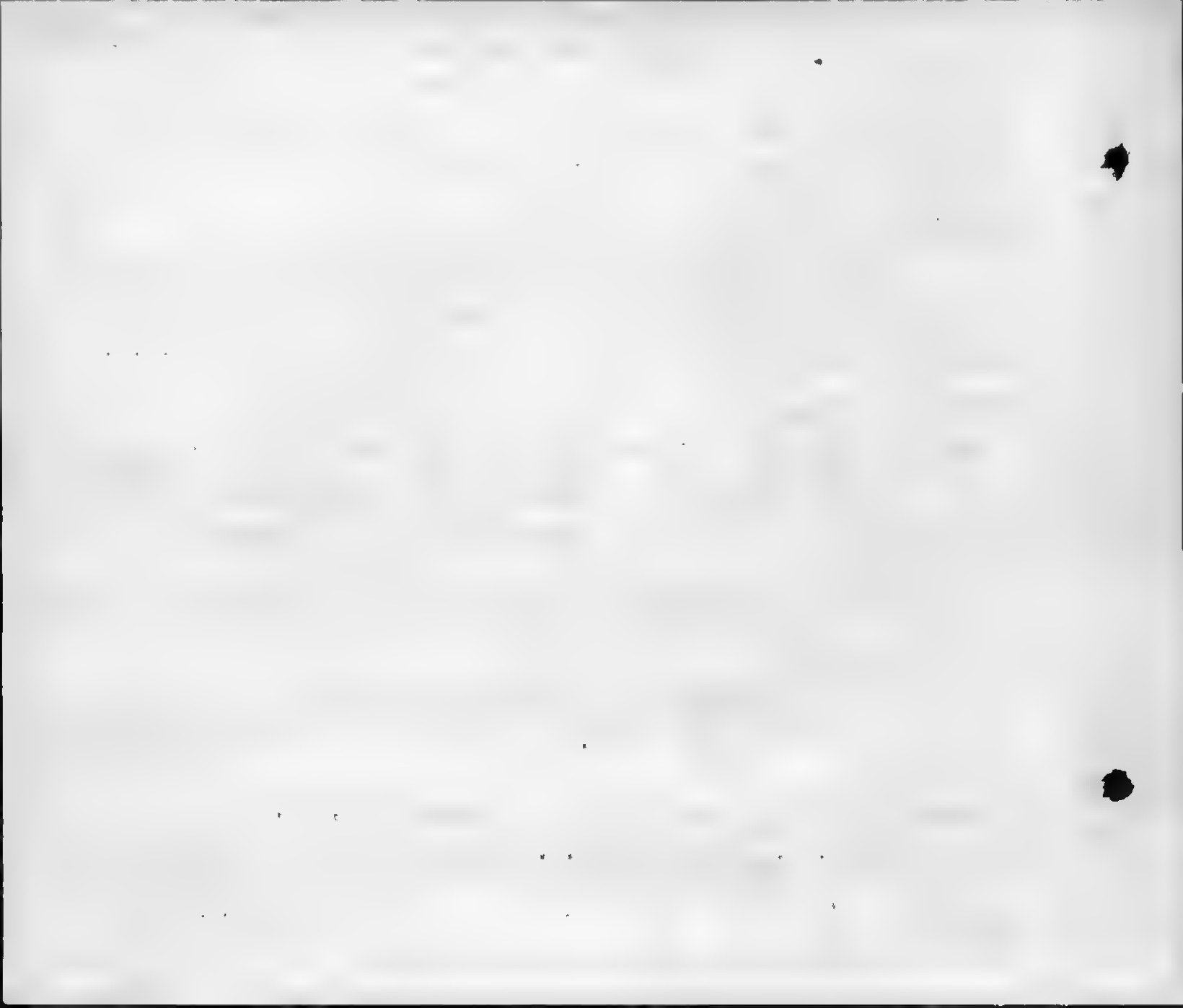
05428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greensboro</u>		c. LENGTH OF STAY IN 1b <u>76 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>H</u> Last <u>Hubbard Sr.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Hubbard</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-01-5074</u>	
17. INFORMANT <u>Martha Hubbard Greensboro, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u>			
DUE TO (b) <u>Generalized Arteriosclerosis</u>			
DUE TO (c) <u> </u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spastic Gastro-enteritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 8, 1958</u> to <u>May 9, 1959</u> , that I last saw the deceased alive on <u>May 8, 1959</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u>		DATE SIGNED <u>5/12/59</u>	
ACTUAL SIGNATURE <u>Chas. H. Stonesifer</u>		M.D. <u>Chas. H. Stonesifer, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>Chas. H. Stonesifer, M.D.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	22d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaire</u>		ADDRESS <u>Greensboro, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05429

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>Caroline</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Caroline</u>	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Rural Henderson</u>		c LENGTH OF STAY IN 1b <u>65 Yrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>		e STREET ADDRESS <u>None</u>	
3 NAME OF DECEASED (Type or print) <u>Jessie</u> First <u>Richardson</u> Middle <u>Hughes</u> Last		4 DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/9/1896</u>
9 A E (In years, day) <u>63</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Alexander Hughes</u>		14 MOTHER'S MAIDEN NAME <u>Mariam Satterfield</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17 INFORMANT <u>Norval Hughes</u>		Address <u>Henderson, Maryland</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis Chronic</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Previous 4m-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dawson O. George</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais & Sons, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE SIGNED <u>2-28-59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 72 hours after death. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



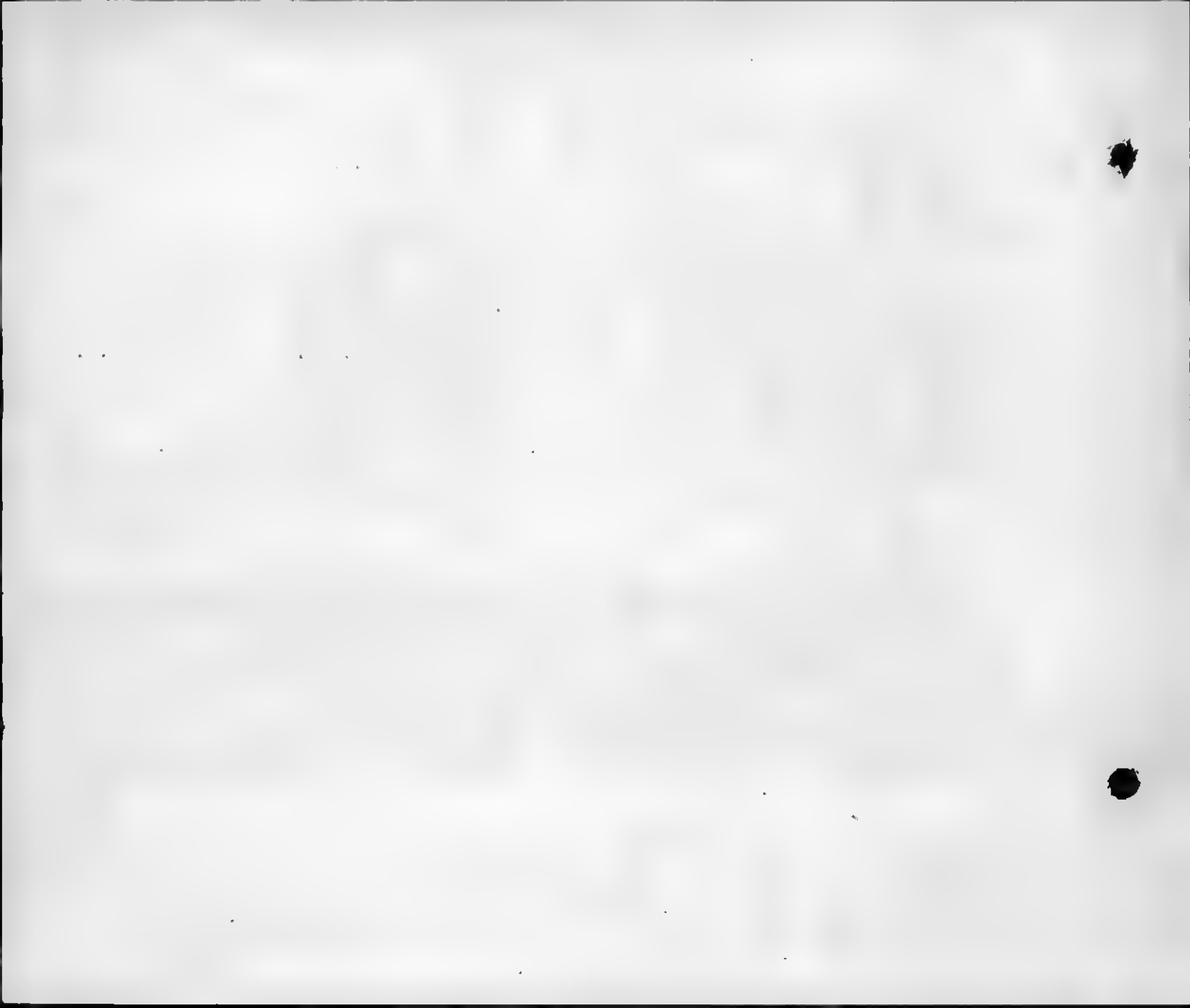
5439 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lambert Middle Moward Last James		4. DATE OF DEATH Month May Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 2 Days 20	11. IF UNDER 24 HRS Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Talbot County, Md.	
11. BIRTHPLACE (State or foreign country) Md. U.S.		12. CITIZEN OF WHAT COUNTRY? Md. U.S.	
13. FATHER'S NAME John W. James		14. MOTHER'S MAIDEN NAME Mary Ann Pritchard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Franklin D. Musbaum, Preston, Md.	
17. INFORMANT Mrs. Franklin D. Musbaum, Preston, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO (c) Arterial Occlusion of large vessel Right leg		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 20 " 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basal Cell Carcinoma of left side of face below eye		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/28 , 19 59 , to 5/17 , 19 59 , that I last saw the deceased alive on 5/16 , 19 59 , and that death occurred at 3:30 p. m. from the causes and on the date stated above			
ACTUAL SIGNATURE James B. Plummer M.D.		DATE SIGNED 5/19/59	
PHYSICIAN'S NAME (Type) Dr. H. B. Plummer		Preston Md. PO Box 1184	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1959	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth H. Thomas		24. REC'D BY REGISTRAR MAY 21 '59	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5440

CERTIFICATE OF DEATH

Reg. Dist. No. 05431

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ridgely	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS Maple Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ada Middle Clara Last Matthews		4. DATE OF DEATH Month 5 Day 25 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/1871
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 87	IF UNDER 24 HRS. Days 87 Hours 87 Min. 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leanders S. Matthews		14. MOTHER'S MAIDEN NAME Martha Rosana Powers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Stella M. Matthews Ridgely, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Generalized Osteoporosis -			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 53 to Feb 59 , that I last saw the deceased alive on Feb 11 , 19 59 , and that death occurred at 9 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ridgely, Md. DATE SIGNED 5/26/59			
ACTUAL SIGNATURE C. H. WINNA COTT M.D.		DATE SIGNED 5/26/59	
PHYSICIAN'S NAME (Type) C. H. WINNA COTT		Ridgely, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/27/59	22c. NAME OF CEMETERY OR CREMATORY Ridgely	22d. LOCATION (City, town, or county) (State) Ridgely, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleais Greensboro Md.		24a. REC'D BY REGISTRAR MAY 27 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12 FilmG243 6-5-59 et

5441 CERTIFICATE OF DEATH

05432

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>CAROLINE</u> MARYLAND CITY OR TOWN <u>RURAL DENTON</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u> CITY OR TOWN <u>RURAL DENTON</u> STREET ADDRESS <u>1</u> (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>ELIZABETH HEINEL THUNS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 13 19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>JUNE 9, 1872</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Jir</u>				14. MOTHER'S MAIDEN NAME <u>Appalona</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Fredrick Reibel, Denton Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260X IMMEDIATE CAUSE (A). <u>Renal Insufficiency, myocardial failure.</u> ANTECEDENT CAUSE(S) DUE TO (B). <u>Diabetes mellitus.</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C). <u>Arteriosclerosis, generalized</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>260X</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 12, 1959</u> , to <u>May 12, 1959</u> , that I last saw the deceased alive on <u>May 12, 1959</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Winnacott</u> M.D.				DATE SIGNED <u>5/18/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 17, 1959</u>	NAME OF CEMETERY OR CREMATORY <u>Denton</u>	LOCATION (City, town, or county) (State) <u>Denton, Maryland</u>			
24. REC'D BY REGISTRAR DATE <u>MAY 22 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Robinson, Denton Md.</u>			

10585

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - AUGUST 19

STATE CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF BIRTH

REMARKS

REMARKS

REMARKS

DATE OF BIRTH

CAUSE OF DEATH

REMARKS

FILE NO.